Platform Cooperativism Consortium

INSTITUTE FOR THE COOPERATIVE DIGITAL ECONOMY

CO-DESIGNING A HEALTH SERVICES COOPERATIVE IN MEXICO

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Summary

Mexico's healthcare system remains split between two insufficient models: a fragmented public sector that struggles to provide universal coverage and stable working conditions for medical professionals, and a private sector whose costs place quality care beyond the reach of much of the population. At the same time, digital health tools—including telemedicine, shared electronic records, and artificial intelligence—are expanding rapidly and are often presented as solutions to problems of access and efficiency. Yet these technologies also raise major questions of governance, affordability, data control, clinical reliability, and institutional design. Their value depends not only on technical capacity but also on the social arrangements within which they are embedded.

This study explores a third pathway grounded in the social and solidarity economy: the co-design of a health services cooperative in Mexico. Drawing on Participatory Action Research and comparative case study analysis of Unimed in Brazil and Fundación Espriu in Spain, the paper examines whether cooperative institutional forms can respond to structural failures in Mexico's health system while integrating digital tools in socially accountable ways. The research began as an exploration of a physician-led cooperative model and, through the participatory design process, evolved into a more specific proposal for a multi-stakeholder elderly care cooperative in Monterrey.

The paper argues that a health cooperative is not simply an alternative organizational form but a potentially transformative response to the limits of both bureaucratic public provision and profit-driven private medicine. In this context, digitalization should not be understood merely as modernization, but as a terrain of struggle over ownership, control, and social purpose. Platform cooperatives—digitally enabled enterprises owned and governed by workers, users, or multiple stakeholders—offer a particularly relevant framework for reimagining healthcare infrastructure in Mexico around care, democratic participation, and social justice rather than extraction and shareholder value.

Mexico's Healthcare System Between Fragmentation, Inequality, and Digital Transition

Mexico's healthcare system is marked by deep structural fragmentation. Public health services are divided among several federal institutions, most notably the Mexican Institute of Social Security (IMSS), which covers roughly 51 percent of the population—primarily formal-sector workers—and the Institute of Security and Social Services for State Workers (ISSSTE). Over the past decade, this institutional architecture has undergone repeated reforms, moving from Seguro Popular to INSABI and more recently toward the consolidation of IMSS-Bienestar. Despite these reforms, universal coverage remains incomplete: health coverage in Mexico stands at roughly 77 percent, far below the OECD average of 97 percent.[1] This gap is compounded by chronic underfunding, with Mexico allocating only 5.7 percent of GDP to health, compared to the OECD average of 9.2 percent.[2]

Alongside this fragmented public system stands a strong but exclusionary private sector. Private care has grown in part because many patients perceive it as faster and more reliable than public provision, despite its high costs. Out-of-pocket spending now accounts for approximately 47 percent of total health expenditure in Mexico, placing substantial burdens on households.[3] The system also faces a serious workforce deficit, with only 2.4 doctors per 1,000 inhabitants, compared to the OECD average of 3.5.[4] These shortages are intensified by precarious labor conditions, including temporary contracts, low wages, and high levels of occupational stress.[5]

Digital health has emerged as both a necessity and a contested terrain. Major private hospitals in metropolitan areas already use artificial intelligence and machine learning for diagnostics in fields such as radiology, cardiology, and oncology, yet adoption across the country remains highly uneven. One major obstacle is the digital literacy gap: only a small percentage of healthcare professionals in Mexico have received formal AI training.[6] In January 2026, amendments to the Ley General de Salud introduced the National Universal Health Registry,

aiming to reduce institutional silos by allowing patients to access care across IMSS, ISSSTE, and IMSS-Bienestar regardless of labor status.[7] The reform also established three core principles for digital health governance: technovigilance for AI-driven medical devices, data sovereignty through locally trained algorithms, and strengthened human oversight that preserves physicians as final clinical decision-makers. Against this backdrop, the central question of this paper is whether a health services cooperative could complement healthcare delivery in Mexico, and what lessons from international cooperative experiences might help address the country's persistent problems of access, equity, and professional precarity.

Health Services Cooperatives as an Institutional Alternative

A health services cooperative is a healthcare organization grounded in cooperative principles and democratic governance. It offers a values-based alternative to both public bureaucracy and investor-owned private medicine. Rather than maximizing profits, health cooperatives prioritize social and community objectives, place patients at the center of care, and reinvest surpluses into improving services, infrastructure, and technology.[8]

Health cooperatives vary in membership composition. Some are professional or worker cooperatives composed of physicians, nurses, or other providers who seek to improve working conditions while delivering high-quality care. Others are user or consumer cooperatives formed by patients seeking more affordable or better services. Still others are producer cooperatives—for example, pharmacists organizing collectively around procurement and distribution—or multi-stakeholder cooperatives that bring together workers, users, and community members in shared governance structures.[9]

What distinguishes health cooperatives from traditional firms is not simply ownership form but institutional purpose. In cooperatives, control follows the principle of one member, one vote rather than one share, one vote. Surpluses are reinvested rather than distributed to external shareholders. Governance is

participatory rather than capital-weighted. As part of the social economy, health cooperatives are often better positioned to address unmet needs, serve populations neglected by profit-driven models, and balance service quality with affordability.[10] In sectors where market failures and inequities are persistent, they offer a potentially important institutional alternative.

International Lessons: Unimed and Fundación Espriu

Two international cases are especially relevant to the Mexican context. The first is Unimed in Brazil, the world's largest medical work cooperative system. Founded in 1967 in Santos, São Paulo, under the leadership of Dr. Edmundo Castilho, Unimed emerged in response to commercial "group medicine" firms that threatened to control physicians' labor and commodify care.[11] Today the system comprises hundreds of cooperatives and physician members serving millions of patients across Brazil. Unimed demonstrates the power of physician ownership at scale: it protects clinical independence, improves bargaining power, and allows physicians to organize healthcare outside traditional investor-owned structures. At the same time, it also reveals structural tensions. Fee-for-service incentives can conflict with cost control, governance can become politicized when physicians occupy managerial roles without adequate training, and scale can push cooperatives toward centralization and reduced local autonomy.[12]

The second case is Fundación Espriu in Spain, a private non-profit network rooted in earlier cooperative healthcare experiments led by Dr. Josep Espriu. Unlike Unimed, Fundación Espriu is especially relevant as a model of co-management between medical professionals and users. Its institutions combine physician-owned and user-owned forms, particularly through SCIAS, the cooperative that manages the Hospital de Barcelona.[13] This model shows the promise of multi-stakeholder healthcare governance: stronger accountability, closer alignment between providers and users, and a more explicit social orientation. At the same time, it also illustrates the complexity of shared governance, the challenge of preserving cooperative identity over time, and the difficulty of balancing different

interests within the same institution.[14] Taken together, these two cases suggest two possible pathways for Mexico. Unimed demonstrates the strengths and risks of physician-led scaling; Fundación Espriu demonstrates the promise and complexity of multi-stakeholder co-governance.

Lessons for the Mexican Cooperative Model

The potential integration of a health services cooperative into the Mexican landscape requires a rigorous comparative analysis of existing international benchmarks. Specifically, the physician-centered Unimed model from Brazil and the multi-stakeholder Espriu model from Spain offer two distinct paths toward addressing Mexico's systemic challenges, characterized by institutional fragmentation, excessive out-of-pocket (OOP) spending, and severe professional precariousness.[15]

The primary advantage of the Unimed model for the Mexican context lies in its capacity to empower healthcare professionals against the accelerating "mercantilization" of the private sector. Currently, 64% of hospital units in Mexico are private, often controlled by powerful corporate conglomerates where physicians frequently encounter exploitative labor conditions.[16] By adopting a medical worker cooperative structure, Mexican doctors could transition from being precarious contractors to owner-operators of their own healthcare network. However, the efficacy of this model varies by specialty. For general practitioners, a worker-centered cooperative may struggle to compete directly with the convenience and low cost of Consultorios Adyacentes a Farmacias (CAF), such as Farmacias del Ahorro or Farmacias Similares, which have become the primary point of care for acute illnesses in Mexico.[17] Conversely, for specialists, the associative advantages of a cooperative would provide the necessary scale to establish a reputable brand, pool expensive diagnostic infrastructure, and cultivate community trust.[18]

In contrast, the Fundación Espriu model offers a "comprehensive health cooperativism" that may be more strategically aligned with Mexico's broader societal needs. The distinctive advantage of the Espriu framework is its multi-stakehold-

er governance, which places physicians and users (patients) at the same decision-making table on an equal footing.[19] Given that out-of-pocket expenditure in Mexico accounts for 47% of total health spending—one of the highest rates among OECD nations—including the patient in governance serves as a powerful mechanism for accountability and cost-containment.[20]

Unlike the Unimed model, which can occasionally experience internal tensions between the maximization of physician income and the sustainability of service costs, the Espriu model's inclusion of users ensures that surpluses are strictly reinvested into medical technology and infrastructure for the benefit of the community. Therefore, while a physician-led workers' cooperative may serve as a pragmatic starting point to stabilize medical labor, the long-term objective for a Mexican pilot should be the transition toward a multi-stakeholder model to ensure equitable access and social sustainability.

The Cooperative Landscape in Mexico

Cooperatives in Mexico have deep roots in agrarian reform, labor movements, and post-revolutionary social policy. The Ley General de Sociedades Cooperativas defines them as organizations based on solidarity, mutual aid, democratic governance, and equitable distribution of surpluses.[21] According to the Instituto Nacional de la Economía Social (INAES), cooperatives are a central component of Mexico's social and solidarity economy and are particularly concentrated in savings and credit, production and services, and worker-owned enterprises. Overall, the country hosts a robust cooperative sector comprising approximately 18,000 cooperatives and around 9 million members.[22] These organizations play an important role in rural development, agricultural production, and financial services. Prominent examples include financial cooperatives such as Caja Popular Mexicana and large worker-owned enterprises like Cruz Azul.

In recent years, new cooperative initiatives have also emerged in indigenous and urban contexts, particularly in regions such as Oaxaca, Yucatán, and Mexico City, where projects focused on sustainability, community development, and local

economic resilience have expanded the reach of the cooperative model. There are important examples of success. Savings and credit cooperatives have expanded financial inclusion in underserved communities. Fishing and agricultural cooperatives have developed ecologically sustainable resource management systems. Worker-owned enterprises such as Pascual demonstrate that self-managed production can survive in competitive industries.[23]

Yet the sector also faces persistent structural barriers. Cooperatives often struggle to access capital because they lack equity investor incentives and specialized financial instruments. In capital-intensive sectors such as healthcare, this is a major constraint. Governance can also be weakened by managerial gaps, opaque oversight, and informal leadership concentration. Informality, regulatory fragility, and the presence of pseudo-cooperatives further undermine legitimacy. Finally, in liberalized markets, small cooperatives often struggle to compete with vertically integrated corporations unless they are embedded in strong federated networks.

Research Process

This study uses Participatory Action Research (PAR) to collaboratively design a health cooperative model in partnership with physicians and other relevant stakeholders. Rather than treating physicians as research subjects alone, the project treats them as co-designers of an institutional alternative.[24] The research unfolded in three phases. The Foundational Phase focused on relationship-building, trust, and the identification of potential members through introductory meetings and open discussion. The Diagnosis and Engagement Phase involved semi-structured interviews and focus groups with physicians from both public and private sectors, including specialists and general practitioners.[25] These discussions explored working conditions, income structures, clinical autonomy, and burnout. The Vision-Building and Cooperative Design Phase, currently underway, uses participatory workshops to define the cooperative's mission, governance model, and economic structure. Through this phase, the project gradually moved

toward a specific proposal: a multi-stakeholder elderly care cooperative in Monterrey.

The study draws on the participation of physicians working across both public and private healthcare systems in Monterrey and Nuevo León. Participants include a private orthopedic specialist, a general surgeon working in both sectors, and a surgical resident. This cross-sectoral experience allows participants to reflect on both public institutional constraints and private market pressures.

Physicians' Motivations, Constraints, and Institutional Preferences

Participants reported that their greatest professional satisfaction comes from long-term relationships with patients and independent clinical decision-making. Their interest in a cooperative model was largely pragmatic: a way to stabilize patient flow, improve economic security, and support younger specialists. At the same time, they identified serious structural constraints, including restrictions imposed by private hospitals and administrative burdens. Such conditions were seen as direct limits on professional autonomy. Although most participants were not formally familiar with the language of the social economy, the idea of a self-managed professional organization resonated positively as a mechanism for fairer income distribution and broader patient access.

Participants envisioned a cooperative built around practical shared infrastructure: collective scheduling, specialized consultation spaces, and joint purchasing. Governance needed to be professionalized, with clear roles and financial transparency. Digital infrastructure—especially a shared electronic health record system—was seen as essential. Economically, participants proposed a hybrid model based on affordable fees and membership contributions. Transparency and accountability emerged as non-negotiable conditions for trust.

Key Institutional Lessons for Cooperative Healthcare in Mexico

The findings suggest a strong alignment between physicians' normative values and cooperative governance principles. Even without formal training in cooperative theory, participants emphasized democratic participation and protection of clinical autonomy. However, financial sustainability remains the decisive challenge. The Mexican cooperative experience suggests that scale and durability depend on professionalized governance, regulatory legitimacy, diversified revenue streams, and federated alliances.

Toward a Multi-Stakeholder Elderly Care Cooperative in Monterrey

Following the diagnostic phase, the project shifted toward the co-design of a multi-stakeholder elderly care cooperative in Monterrey, suggesting that physician-led cooperative design in Mexico may be most viable not as a fully general healthcare alternative at the outset, but as a strategically focused intervention in an area of acute unmet need, that reflects Mexico's demographic realities: population aging, increasing chronic illness, and the absence of coherent long-term care infrastructure. .The proposed cooperative seeks to reduce fragmentation through pooled resources while involving caregivers, families, and professionals in democratic governance. It is guided by principles of solidarity, equity, and pricing transparency.

The model is explicitly multi-stakeholder. Older adults and their families would participate in governance; caregivers such as nurses would deliver daily care; physicians would provide clinical oversight; and external partners would contribute infrastructure. Services would include geriatric assessments, chronic disease management, home mobility assistance, and palliative care planning. Quality would be monitored through patient satisfaction and functional outcomes.

Institutional Design of the Elderly Care Cooperative

The proposed Elderly Care Cooperative would provide community-based, person-centered services under democratic cooperative governance. Its goal is to create an integrated system of care that connects physicians, nurses, caregivers, patients, and families while ensuring affordability, transparency, and professional autonomy. The cooperative would work in partnership with municipal health systems, public institutions, and technology providers to deliver coordinated services such as geriatric assessments, chronic disease management, specialists support from internal medicine and surgery, and palliative care planning.

International experiences provide practical guidance for institutional design. Brazil's Unimed system shows that physician-owned cooperatives can protect clinical autonomy and create large-scale healthcare infrastructure through collective organization. Spain's Fundación Espriu demonstrates how multi-stakeholder governance—where physicians and patients share decision-making power—can strengthen accountability and align care provision with community needs. The proposed Mexican model combines lessons from both: physician leadership in professional standards and infrastructure, alongside democratic participation from users and caregivers to ensure affordability and social purpose.

To move from concept to practice, different participants would play distinct roles:

For physicians:
Doctors could initiate the cooperative by forming a founding professional group that defines clinical standards, shared infrastructure, and referral systems. Following the example of Unimed, they could collectively pool resources to establish shared consultation spaces, diagnostic equipment, and digital health records. Physicians would also help design governance rules that protect professional autonomy while ensuring transparency in decision-making.

For nurses and caregivers:
Nurses, geriatric specialists, and home-care providers would form a core workforce within the cooperative. They could organize service delivery teams responsible for daily care coordination, home visits, and patient monitoring. Their participation in governance ensures that care models reflect the realities of frontline work and that employment conditions remain stable and fair.

For patients and families:
Older adults and their families would participate as cooperative members with voting rights. Inspired by the Espriu model, this participation creates accountability in pricing, service quality, and resource allocation. Patients could also contribute to advisory committees that evaluate care outcomes and community needs.

For cooperative and financial institutions:
Existing Mexican cooperatives—particularly savings and credit cooperatives—could provide financial infrastructure, credit facilities, and institutional partnerships that support initial capitalization. Federated networks could also help scale the model regionally once the pilot is established.

Digital infrastructure would play a supporting role rather than driving the system itself. Shared electronic health records, telemedicine tools, and data platforms would help coordinate care across providers while maintaining patient data sovereignty and physician oversight.

Conclusion and Next Steps

Mexico's healthcare system faces deep structural challenges: fragmentation, underfunding, and precarious working conditions for healthcare professionals. In this context, a cooperative healthcare model offers a promising institutional alternative capable of strengthening professional autonomy while expanding access to affordable care.

This research suggests that physicians are open to cooperative organization, particularly when it provides shared infrastructure and more stable working conditions. However, international experience shows that cooperative healthcare systems succeed only when three conditions are met: strong capitalization, professionalized governance, and coordinated networks that allow local initiatives to scale.

The immediate next step is the development of a pilot elderly care cooperative in Monterrey. Rather than attempting to replace the existing health system, the cooperative would begin by addressing a clearly defined gap: long-term and geriatric care. This approach allows the model to demonstrate its effectiveness in a specific domain while building trust among providers and patients.

If successful, the cooperative could evolve into a broader healthcare network, linking community-based care, digital health services, and cooperative financing mechanisms. In this sense, the project represents more than a new organization—it offers a practical experiment in reimagining healthcare infrastructure around democratic governance, solidarity, and professional dignity.

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